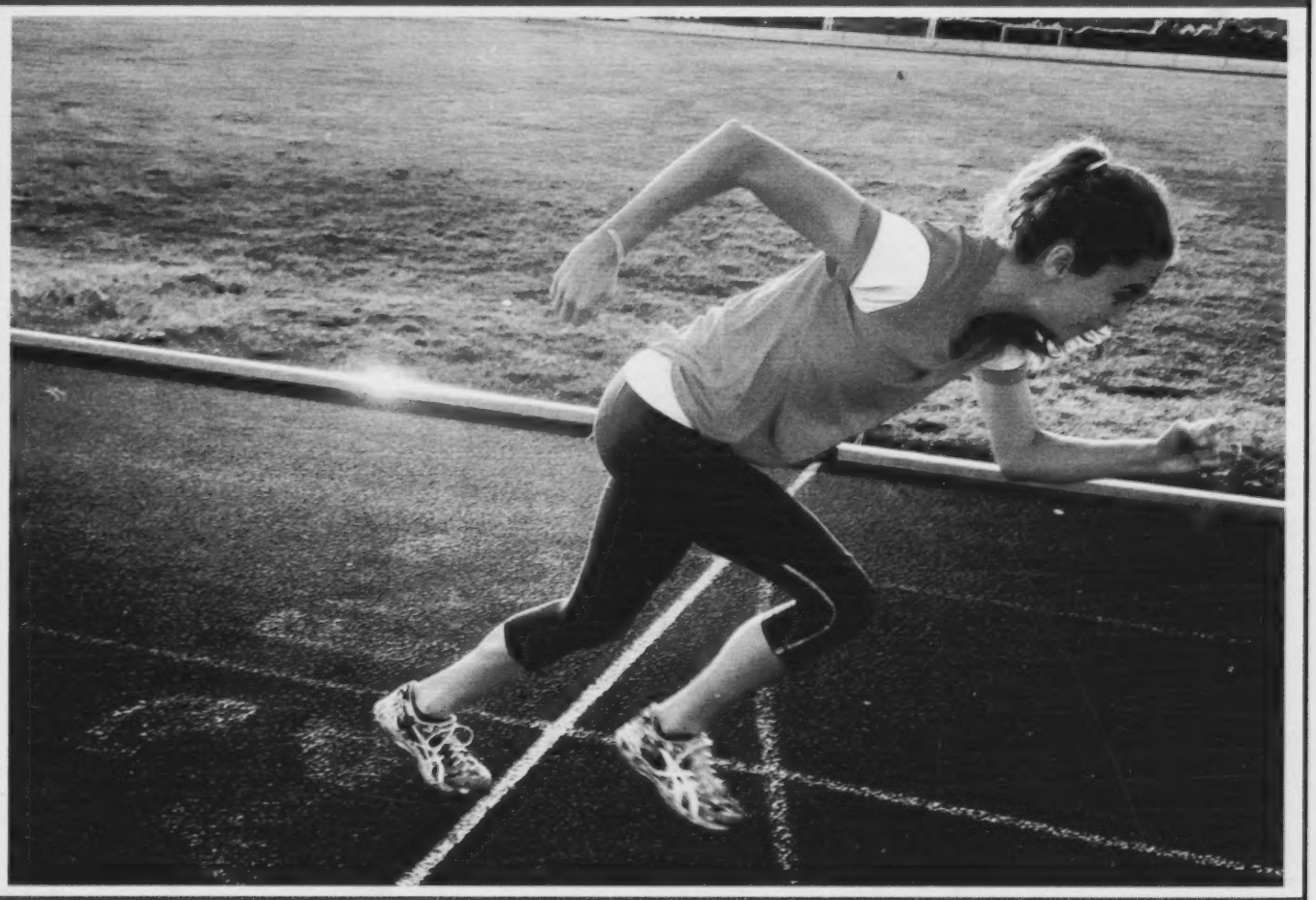
Erie St. Clair **LHIN**



The Momentum of Better

Erie St. Clair Local Health Integration Network

Annual Report 2016–17

For the year ending March 31, 2017

Ontario

Local Health Integration Network

Contents

Message from the Board Chair and CEO 4
Introduction to the Erie St. Clair LHIN 5
Population Health Profile 5
Service Area 5
LHIN Sub-regions 7
Initiatives in the ESC LHIN Region 8
Emergency Department Care 10
Alternate Level of Care 11
Wait Times for Surgical and Diagnostic Imaging Procedures 12
Mental Health and Addictions 12
Chronic Disease Prevention and Management 13
Health Links 14
Community Support Services 14
End-of-Life Care 15
Provincial 15
Hospices 16
Palliative Care Consultation Teams 16
eShift 16
Hospitals 16
Palliative Care Education 16
Medical Assistance in Dying (MAID) 17
eHealth 17
TransForm Shared Service Organization (SSO) Regional Project Management Office (PMO) 17
ConnectingOntario and the Connecting South West Ontario (cSWO) Program 17
Health System Funding Reform 18
Integration 18
Community Engagement 19
Francophone Engagement 20
Indigenous Engagement 21
Strategic Direction 1: Reduce Health Inequities for Indigenous People 21
Strategic Direction 2: Improve Indigenous Patients' Access to Health and Prevention Services 22
Strategic Direction 4: Expand Availability of Mental Health/Addiction Services for Indigenous People 24

Strategic Direction 5: Enhance the Quality/Availability of Reliable Information and Data for Health Planning 24
Additional Activities 24
Focus Areas for 2017–18 25
Community Engagement Initiatives 26
Board of Directors 44
Ministry-LHIN Accountability Agreement (MLAA) 45

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Message from the Board Chair and CEO

Every day do something that will inch you closer to a better tomorrow.

– Doug Firebaugh

"Better Care, Better Experiences, Better Value": three short phrases that form our vision statement and that commonly roll off our tongue. We've been talking about these goals for a few years, and we are now in a position to measure how well we've done.

When we're sick, getting better can seem to take an inordinate amount of time; sometimes we grow impatient wanting to be healthier sooner. As an essential part of the health care system, we at the Erie St. Clair LHIN feel the same. Seeing improvements does seem to take too long, but we know that each investment we make, each program we support, and each wait time that gets reduced builds momentum toward improvement.

We know we're headed in the right direction. For example:

- Our local system has been the best performer in the province on preventing hospital readmissions
- Rates for patients waiting for the most appropriate bed have dropped substantially in the last year
- Rates for emergency department (ED) visits best managed elsewhere have dropped, which means people are increasingly accessing care in the community
- Access to hip surgeries has shown improvement
- Wait times for CCAC home care are some of the lowest in the province

In areas where we have not made improvements, we are continuing to focus efforts.

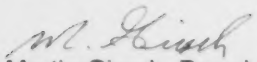
This year, the *Patients First Act, 2016*, was passed. The Act is an historic piece of legislation that has the potential to shape the future of health care for years to come. Putting patients first is no longer just a saying. Patients and families will now be included in all health care decisions.

Patients commonly tell us that the care they receive is excellent, but that moving from agency to agency was difficult. Patients want to more easily move through their health care journey, spending less time seeking care and more time healing.

Continuing the momentum of "Better Care, Better Experience, Better Value" is everyone's work: planners, funders, providers, clinicians, and, most importantly, patients and families, all have a role in making our health care system better. It will be from the strength of collaboration, greater transparency, and enhanced accountability that we can continue to make meaningful improvement. Opening our minds to change, and opening our ears to listen and our eyes to see through the lens of the patient, will guide us to a place of better.

Thanks to all of our partners, patients, and families for your continual dedication to patient care, your tireless efforts, and your continued quest for improvement.

Sincerely,



Martin Girash, Board Chair

Ralph Ganter,CEO

Introduction to the Erie St. Clair LHIN

The ESC Local Health Integration Network (LHIN) is one of 14 LHINs in Ontario. The LHINs were established in 2006 to manage the planning, integration, performance, and funding of the health care system. This responsibility includes services delivered by:

- Hospitals
- Long-term care (LTC) homes
- Community Care Access Centres (CCACs)
- Community support service (CSS) agencies
- Mental health and addictions agencies
- Community health centres (CHCs)

Population Health Profile

The health service needs of Erie St. Clair residents are significantly different from those of Ontario as a whole. Compared to the province, Erie St. Clair has:

- A higher number of people living on low incomes
- A population with a lower life expectancy
- A higher proportion of seniors
- A higher incidence of individuals who are overweight
- A higher proportion of individuals with poor lifestyle habits such as smoking, drinking, poor nutrition, and inactivity
- Higher rates of chronic conditions such as cardiovascular diseases, cerebrovascular diseases, diabetes, high blood pressure, chronic obstructive pulmonary disease (COPD), and arthritis

For more detailed information on Erie St. Clair's population health care utilization, or demographic information, see *ESC LHIN's Integrated Health Service Plan 4 – 2016-2019* (IHSP 4) at http://www.eriestclairlhin.on.ca/Accountability/IHSP/IHSP4-2016-2019/IHSP%204%20-%202016-2019.aspx?sc_Lang=en.

Service Area

The ESC LHIN serves approximately 636,000 people in the regions of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex (see Figure 1). Although these regions are independent and each has unique qualities, they also share many commonalities, such as being surrounded on three sides by the Great Lakes. The area's urban–rural mix is economically dependent upon the agricultural, petrochemical, and automotive industries. As well, the region's American neighbours not only influence the local economy and trade, but also affect the use and perception of health care.

Windsor/Essex comprises 63% of the population; Sarnia/Lambton, 20%; and Chatham-Kent, 17%. The population includes immigrants (16.9%), seniors (18.4%; those aged 65+), Francophones (3.3%), and Indigenous peoples (2.5%).

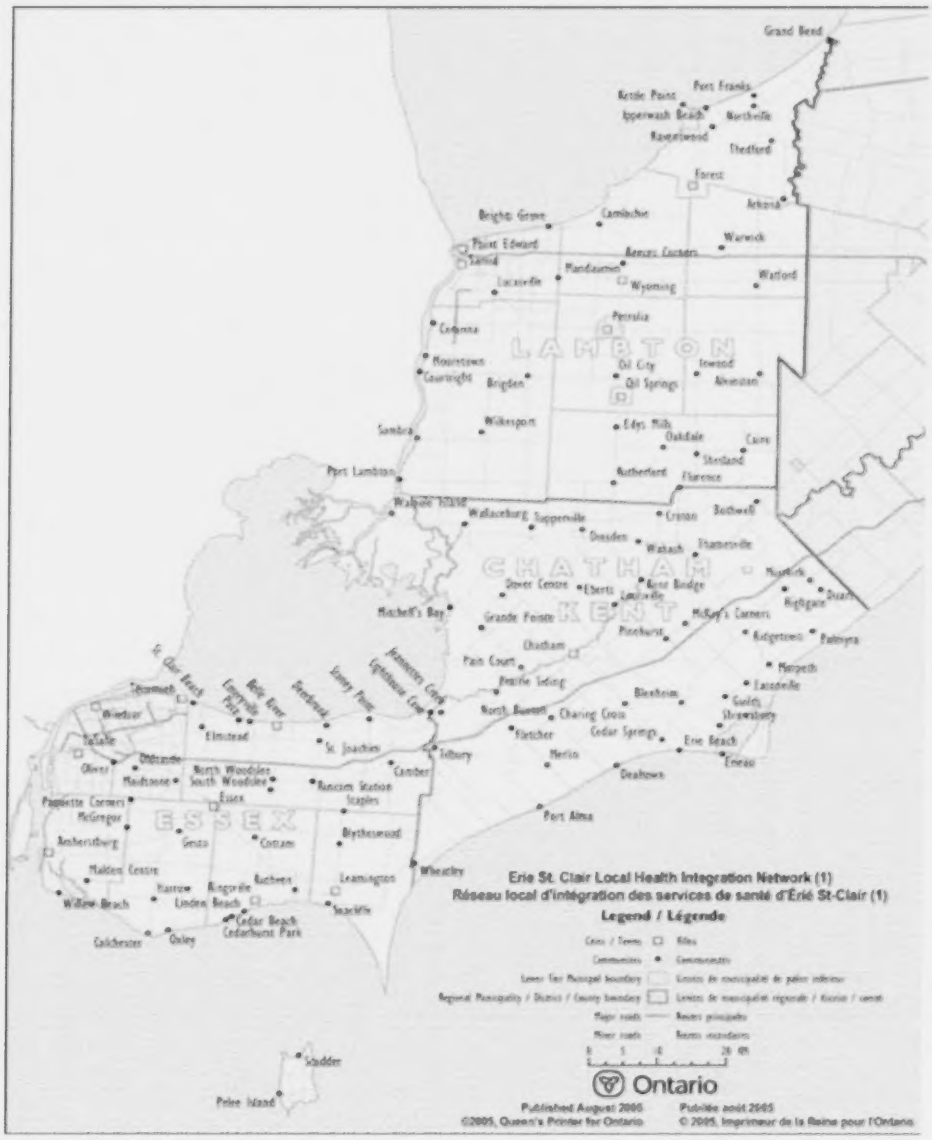


Figure 1: Map of the Erie St. Clair LHIN Region

LHIN Sub-regions

The *Patients First Act, 2016,* provided guidance to the LHINs to help them establish smaller geographic planning sub-regions so that they could better understand and address patient needs at the local level. The premise is that, by looking at care patterns through a smaller lens, LHIN staff will be better able to identify and respond to community needs and ensure that patients across the region can access the care they need, when and where they need it. The ESC LHIN has identified six sub-regions (see Table 1).

Table 1: ESC LHIN Sub-regions

Sub-region	Characteristics
Windsor	• Population: 210,091 • 232 primary care providers • 16 CHCs • One acute hospital • One tertiary hospital
Tecumseh Lakeshore Amherstburg Lasalle	• Population: 108,355 • 59 primary care providers • 16 CHCs
Essex South Shore	• Population: 71,927 • 39 primary care providers • 16 CHCs • One acute hospital
Chatham City Centre	• Population: 69,036 • 49 primary care providers • 15 CHCs • One acute hospital
Rural Kent	• Population: 32,648 • 14 primary care providers • 15 CHCs • One acute hospital
Lambton	• Population: 126,199 • 102 primary care providers • 12 CHCs • One acute hospital

Initiatives in the ESC LHIN Region

In alignment with the Ontario government's current vision for health care, including *The Patient's First Act, 2016; Patients First: Action Plan for Health Care*; the IHSP 4; and ESC LHIN's *Annual Business Plan 2016–2017*, the ESC LHIN undertook a number of strategic initiatives this year in order to move toward achieving its vision of "Better Care, Better Experiences, Better Value" for the residents of Erie St Clair. These achievements included the following:

- ESC LHIN hospitals reduced their ALC rate from 17.3% to 15.9%
- All 36 long-term care (LTC) homes in the ESC LHIN region achieved a 97% occupancy target in 2016, reflecting strong collaboration between the homes, the region's Community Care Access Centre (CCAC), and the ESC LHIN
- The ESC CCAC achieved the shortest wait times in Ontario for admission to LTC homes
- The Chatham-Kent Breathe Well Pulmonary Rehabilitation program improved the quality of life for 114 patients with COPD by helping them manage their chronic disease through education, exercise, and support
- The CCAC Intensive Hospital to Home (IHH) program provided support to all ESC LHIN hospitals throughout the region. Since its inception in early 2016, the program has safely transitioned 68 complex patients from hospital to home
- Live Oculys reporting of Bluewater Health's ED helped the hospital, the ESC CCAC, and the ESC LHIN work together to address flu-season surges and pressures. The ESC LHIN also introduced a new, rigorous quarterly performance-review process with its mental health, addictions, and community support service-agency partners
- The Chatham-Kent Nurse-Led Outreach Team performed 118 assessments in three of the five LTC homes in Chatham-Kent, which resulted in a reduction in avoidable ED visits and decreased hospital admissions
- Collaborative Falls Prevention clinics installed approximately 420 grab bars
- Attending nurse practitioners (NPs) began working in LTC homes, thereby improving access to primary care in these facilities
- CareLink, the ESC LHIN regional health transit collaborative comprising eight agencies, bought seven new replacement vans to better address the transportation needs of people seeking health care
- Implementation of a cross-continuum hip fracture care pathway has supported 111 more patients with hip fractures to access inpatient rehabilitation, a 45% increase since 2012, and now nearing its target of 60%
- A Community Rehabilitation Outreach Team (CRRT) launched in Windsor/Essex at Hôtel-Dieu Grace Healthcare (HDGH) provided

specialized in-home rehabilitation for 45 patients with stroke, resulting in shorter hospital lengths of stay (LOS) for these patients

- The Southwest Ontario Aboriginal Health Access Centre expanded into the ESC LHIN region. The Centre provided primary care services to 490 patients, child and youth mental health and addiction services to 88 patients, and traditional healing services (individual and group sessions) to 140 patients
- The Diabetes Central Intake process has been successfully implemented in the ESC LHIN region, with the goal to become fully electronic and ensure that even more people living with diabetes have access to diabetes education and supports
- The Victorian Order of Nurses (VON) Immigrant Health Clinic served 900 refugees/immigrants, providing service in 53 languages, with an 85% referral rate to a primary care provider
- Chatham-Kent's Rapid Assessment Intervention Treatment Team (RAIT), an integrated mental health access model that includes direct linkages with primary care, served 319 individuals, 93% of whom were seen within a target time of 72 hours. The RAIT program had a dramatic, positive effect on repeat ED visits
- A Transitional Stability Centre day program for individuals with mental health and addiction issues was established in Windsor/Essex County. It served 428 individuals
- The Behavioral Supports Ontario (BSO) program was expanded to four ESC LHIN hospitals; they now have specialized behavior navigators to assist with transitions back to LTC homes or elsewhere in the community. Recent funding increases provided enhanced internal champions for all 36 LTC homes in the region
- The ESC LHIN region is now served by three hospices, one in each county. Chatham-Kent and Erie Shores both opened new 10-bed hospices in spring 2106. The addition of these two hospices brought the total number of hospice beds available in Erie St. Clair to 38. The Hospice of Windsor and Essex County and Sarnia's St. Joseph Hospice continue to provide excellent care in residential beds and in community-based programs
- The eShift program provided through the ESC CCAC helped more than 380 end-of-life clients receive care in their own homes during their palliation. The average number of patients supported every month through this program was 28, with an average LOS of 11.5 days
- Assisted Living Southwestern Ontario (ALSO) expanded and now provides assisted living/supportive housing services in French to Francophone seniors living at Résidence Richelieu in Windsor
- Telehomecare services were expanded ESC LHIN-wide and served 554 clients this year. In Windsor/Essex, clients with congestive heart failure (CHF) and COPD experienced significantly fewer ED visits after joining the Telehomecare program

- Preparation and readiness initiatives for the transition of the ESC CCAC to the ESC LHIN on June 21, 2017, continued throughout the year

Emergency Department Care

The ED is a place that must be available when people need it most. It is also one of the busiest areas within a hospital.

Addressing wait times in the ED continues to be a key priority for the ESC LHIN. Wait times are a complex challenge that must be addressed on many levels. It takes the collaborative efforts of patients, physicians, nurses, clinicians, administrators, community partners, and patients to make incremental improvements.

One of the strategies used to improve wait times is to strengthen community care through investment and collaboration, and ensure that appropriate and timely care are accessible to patients in care settings outside of the ED. (Several of these initiatives are highlighted on page 7.)

The ESC LHIN continually measures key indicators and works with its partners to help improve wait times in the region. Patients' stories and experiences help the LHIN understand what has worked well, and what needs more attention. When we better understand which areas need the greatest improvement, we can focus our efforts and measure the results.

Areas of continued focus for ED improvement by the ESC LHIN include:

- Shorter wait times
- Patient flow throughout the health care system, in order to improve wait times
- Individualized discharge plans created in collaboration with care partners
- Greater access to community services

Key initiatives undertaken in 2016–17 to improve wait times included:

- Enhanced physician hours at peak times
- Improving patient flow for mental health patients, including the implementation of short-stay units at Windsor Regional Hospital to move patients with mental health conditions through the ED more quickly. This has also improved Windsor Regional's psychiatry consultation arrival times
- Avoiding ED visits by investing in community care services
- The use of DIVERT by the ESC CCAC (**D**etection of **I**ndicators and **V**ulnerabilities for **E**mergency **R**oom **T**rips) to categorize patients at risk of ED visits
- Continuing to invest in chronic disease management programs, such as the Breathe Well Pulmonary Rehabilitation program, that improve health outcomes and reduce hospital usage. The combination of hospital, community, and primary care programs and collaboration have led to positive outcomes for patients
- Implementing rapid assessment zones (RAZs) and clinical decision units (CDUs), which allow for short-term monitoring, investigation, and treatment to support the philosophy of "right place, right time, right care," and avoid unnecessary admissions to the hospital

- Successful implementation of the RAZ in Chatham, which decreased time to physician initial assessment in the ED

The ED will always be an essential service in our health system, and it needs to be ready and available to treat the most ill patients. It is also important to ensure that community and primary care options are available to address less urgent needs. By focusing on linkages with primary care, improving chronic disease management, increasing access to mental health and addictions care, and providing improved access to community supports, the ESC LHIN is working toward greater community options for when an ED visit could be avoided.

Alternate Level of Care

Receiving the right care in the right place is the expectation of all patients and the goal of all care providers. Sometimes, however, the transitions between care settings can take longer than patients and providers would like. When patients cannot access the care setting they need, the situation is referred to as ALC: that is, needing an alternate level of care setting that is not available at that time. Being designated ALC means that someone is being cared for in a hospital when they would be better served in another care setting.

Improving ALC benefits everyone. Patients receive care in the most appropriate care setting, wait times are reduced, patient outcomes may improve, and patient flow through the health care system is increased. Alternate level of care continued to be a key priority for the ESC LHIN in fiscal 2016–17. Improvements in this area have been due in part to:

- Increased collaboration between hospital, community, and primary care partners through multi-sectoral discharge planning that includes greater engagement with patient and family members. This has contributed significantly to reduced ALC rates in Essex and Lambton counties
- Increased supports for complex patients to manage their care in the community while awaiting their next destination of care. This includes greater supports for patients with psycho-social barriers to discharge. Examples such as the CCAC's Intensive Hospital to Home (IHH) program, Assisted Living program, and Lambton Elderly Outreach's (LEO's) Subsidized Retirement Home program have contributed to reducing ALC
- Increased unit care rounding, estimation of date of discharge (EDD), and better detection of patients at higher risk of becoming ALC
- Increased rehabilitation capacity at HDGH and Leamington District Memorial Hospital (LDMH), which helps prevent deconditioning while in hospital
- Increased mental health supports throughout the region and behavioural programming through the BSO program in Chatham-Kent, Sarnia/Lambton, and Windsor/Essex. BSO resources within each LTC home and enhanced training have also helped expand clinical capacity for managing complex needs

The ESC LHIN is continually working to improve ALC in our region, because improving patient flow through the hospital and reducing wait times benefits both patients and the health care system. Most importantly, improving ALC benefits patients by giving them access to the right care, in the right place. Reducing ALC will therefore continue to be a key priority for the ESC LHIN in 2017–18.

Wait Times for Surgical and Diagnostic Imaging Procedures

Reducing wait times for surgical and diagnostic imaging procedures across the ESC LHIN continued to be an area of key focus in 2016–17. More detailed information on wait times can be found in Table 6.

Magnetic resonance imaging (MRI) wait times continue to be an area of challenge in our region. Strategies for addressing MRI wait times have been ongoing and have included activities related to the Choosing Wisely program. Additionally, an event hosted in Windsor by the LHIN, in collaboration with the Schulich School of Medicine & Dentistry. This event focused on demystifying radiology in orthopaedic medicine, including best practices in musculoskeletal imaging for achieving better patient outcomes.

Wait times for computed tomography (CT) scans in the ESC LHIN are better than the provincial target and the ESC LHIN is a strong performer compared to other LHINs; however, work will be done next year to further address timely access to CT scans.

Surgical wait times continue to present opportunities for improvement, particularly wait times for knee, cataract, and cancer surgeries. The most significant wait times are for knee replacements. It is hoped that a coordinated access model will help further reduce wait times in the ESC region. As well, the application of queuing theory, as was applied to hip surgery wait times, shows promise. Although access to hip surgery in the ESC LHIN region is still below the provincial target, it has improved significantly since 2015-16.

Wait times for cataract surgeries in the ESC LHIN region are within the provincial target, and work has begun on the creation of a regional Vision Care Strategy to further address eye care and associated wait times in the region.

Wait times for cancer surgery in the region are slightly better than the provincial target and the ESC LHIN continues to work with Cancer Care Ontario and our Regional Cancer Centre to improve performance in this area.

Mental Health and Addictions

Mental health and addictions care remained a key priority for the ESC LHIN in 2016–17. Continued collaborative efforts were made in alignment with the five strategic pillars of the November 2014 update to MOHLTC's 10-year mental health and addictions plan, *Open Minds, Health Minds*:

1. Promote resiliency and well-being in Ontarians
2. Ensure early identification and intervention
3. Expand housing, employment supports, and diversions and transitions from the justice system
4. Provide the right service, at the right time, in the right place

5. Fund based on need and quality

Three local priority areas stem from the five strategic pillars:

1. Housing
2. Primary care/mental health and addictions
3. Coordinated access

The ESC LHIN continues to work with its service providers to implement the recommendations contained in its *Addiction Strategic Plan*. The ESC LHIN has also developed strategies for community housing through Windsor's House of Sophrosyne, a program has been developed to aid victims of human trafficking.

Strong partnerships have also been formed with the Municipality of Chatham-Kent's and the City of Windsor's housing departments by combining rent supplements to collectively support homeless young emerging adults (ages 16 to 29). In the last year, the ESC LHIN provided funding for one NP from the Windsor Essex Community Health Centre's Street Health Team to provide on-the-ground support for two domiciliary hostels with a combined population of over 220 individuals. The ESC LHIN anticipates expanding this primary care mental health and addictions scope to other domiciliary hostels and precarious living environments.

The ESC LHIN has also implemented the Ontario Perception of Care survey in every mental health and addictions agency and three CHCs in the region. This survey tool helps organizations improve service and respond more quickly to community needs.

Chronic Disease Prevention and Management

Five percent of people consume 66% of health care spending in Ontario because of the complexity of their medical conditions; this is true both in the province as a whole and in Erie St. Clair. Statistics such as this provide clear evidence that we can do a better job delivering more coordinated care. To achieve this goal, in 2016–17 the ESC LHIN focused on improvement through better care coordination, enhanced care quality, and the development of evidence-based care pathways.

Compared to the rest of the province, the Erie St. Clair population has higher rates of:

- Arthritis
- Asthma
- Diabetes
- Hypertension
- Mood disorders
- COPD
- CHF
- Heart disease

Of these conditions, the largest proportions of ED visits are associated with arthritis, heart disease, and COPD.

To better prevent and manage chronic diseases, the ESC LHIN continued its work on the implementation of regional chronic disease and prevention management care pathways and service delivery models. Key initiatives in 2016–17 included:

- Creation of a diabetes eReferral system (enhanced central intake)
- Implementation of a standardized discharge checklist designed to reduce unplanned ED visits and hospital readmissions for CHF and COPD patients
- Continuing implementation of standard care paths (in the sub-regions) for COPD, CHF, diabetes, and stroke
- Development of consistent work-plan objectives and measureable indicators (process and outcome) across paediatric diabetes-education programs that are designed to reduce patients' reliance on acute care services

By focusing on prevention and improved chronic disease management, people may live longer and, most importantly, experience a better quality of life.

Health Links

A Health Link is a formal partnership of health care providers that creates a circle of care around a patient, in order to improve care for those who have the most complex medical needs. These health care providers are therefore accountable to one another, to the system, and to the patient. The goal of a Health Link is to provide comprehensive and coordinated care to those who experience significant health challenges, in order to improve or maintain their quality of life.

In 2016–17, the ESC LHIN continued implementing (promoting spread and scale of) the Chatham-Kent Health Link and the Lambton County Lake Huron Health Link, which focus on identifying and connecting patients with coordinated care plans and enhanced access to primary care. A main focus of activity is on the development of technology to improve health care transfers and service information across provider organizations. In January 2017, the Essex County South Shore Health Link (Leamington area) was initiated.

Community Support Services

The importance of strengthening linkages and partnerships with primary care, home care, hospital care, and long-term care continued to be a focus in 2016–17. Working toward a more connected and coordinated health care system is essential to improving access, creating patient-centred care, and improving the quality of care received.

The ESC LHIN believes that community-based health care is important, and understands that people prefer to live in the community as long as possible and to access care as close to home as they can. Additionally, community-based care is essential in promoting health and wellness, providing care when people are ill and helping people recovery from illness.

Because of the important role community services have in our health care system, the

ESC LHIN continued to make investments in community-based care. New community investments in 2016–17 included the following programs:

- Assisted Living Southwestern Ontario: mobile support of daily living expansion
- Canadian Red Cross: Homeward Bound program (Chatham-Kent)
- ESC CCAC: Telehomecare expansion
- VON Canada: Falls Prevention program
- Community Support Centre of Essex County: new vehicles for LHIN-funded health transportation providers
- Alzheimer Society of Chatham-Kent: day program
- North Lambton CHC: dedicated NP for the CHF program

The ESC LHIN provided approximately $1.2 billion in funding to 83 local health service providers; of these, 42 are community-based providers that received $260,128,374 in funding in 2016–17. This figure includes $3,025,400 in new community funding to address:

- Community-based care needs
- LHIN-local priorities
- The expansion of community service capacity
- Increased client acuity
- Reducing ALC pressures
- Falls Prevention program-funding needs
- A needed increase in home care nursing services' maximum hours

End-of-Life Care

The Erie St. Clair region has a long history of excellence in palliative care. Since the ESC LHIN's inception in 2006, it has been a strong contributor to and supporter of the efforts of the Erie St. Clair Hospice Palliative Care Network (ESCHPN), its members, and partners as they work to address gaps and ensure timely access to high-quality palliative care across the region.

Provincial

In March 2016, the Ministry of Health and Long-Term Care (MOHLTC) announced the establishment of the Ontario Palliative Care Network (OPCN) and increased funding. These changes signaled a strong commitment to improving palliative care across Ontario. In May 2016, members of the OPCN spent a day in Erie St. Clair, meeting with people from across the region. Throughout the fall, work was initiated to evolve the current regional network structure.

The OPCN and its partners also participated in capacity planning work that will provide information describing the current state of palliative care-service use across care settings by patients in their last year of life, as well as the development of a tool that the regions can use to support planning and the assessment of the impact of initiatives to strengthen care.

Hospices

In spring 2016, two new 10-bed hospices opened their doors in Erie St. Clair — the Erie Shores Campus, in Leamington, a satellite of the Hospice of Windsor and Essex County; and the Chatham-Kent Hospice, in Chatham. The addition of these hospices brings the total number of hospice beds across the region to 38.

All of the ESC region's hospices enjoy strong community support and are recognized for their commitment to delivering outstanding, compassionate care.

Palliative Care Consultation Teams

Specialist-level Palliative Care Consultation Teams are available in all three counties in Erie St. Clair. These teams, along with specialist physicians and community partners, including the hospices, provide symptom management and support to patients and families in their own homes. In 2016–17, the teams visited more than 1,300 patients.

eShift

In November 2015, the ESC CCAC partnered with the VON to offer an innovative service called eShift. Under this program, a specially trained health care professional (i.e., a personal support worker [PSW]) is able to provide care in the home for patients who are at the end of life. Care is delivered under the direction of a directed registered nurse (DRN). The health care technician and DRN communicate with each other through mobile-monitoring technology.

The response to eShift has been outstanding. Families like having the same people provide care each night, and having health care support in the home means that family members and caregivers can get some much-needed rest.

In 2016–17, eShift was extended across all three ESC counties, and over 380 visits were provided.

Hospitals

Transitions between care settings and supporting care can be challenging for patients. To help ease these transitions, the following initiatives were put in place:

- The Chatham-Kent Health Alliance signed an agreement with the Chatham-Kent Hospice to share two staff between the facilities. This has resulted in faster and more seamless transitions from the hospital to hospice as patients near the end of life
- In Windsor, several projects were undertaken to improve care transitions for patients at the end of life. These included a project at HDGH, the Hospice of Windsor and Essex County, and the ESC CCAC, which collaborated to improve transitions between care settings. The project looked at eligibility, discharge and admit policies, processes, and supporting tools. Successful outcomes included improved patient flow between care settings because of strengthened relationships between staff working in all facilities, shared understanding of organization processes, and improvements in a tool used to admit patients

Palliative Care Education

Work continued in all three ESC counties to build capacity through education. Initiatives included the following:

- The two new hospices engaged hundreds of volunteers and staff in hours of education prior to and through the start-up of the hospices

- ESC CCAC Care Coordinators undertook palliative care education as part of a change in their service delivery model
- The first Indigenous LEAP (Learning Essential Approaches to Palliative Care) in Canada was offered at Kettle and Stony Point First Nation in February 2017
- ESC Palliative Pain and Symptom Management Consultation Program educators offered education to over 400 people through participation in Fundamentals of Hospice Palliative Care, Comprehensive Advanced Palliative Care Education, and Learning Essential Approaches to Palliative Care programs
- The Hospice of Windsor and Essex County offered education throughout the year on a variety of topics
- The Education Collaborative and associated partners supported many projects, including volunteer education, training of new facilitators, education for staff working in LTC homes, and education on advance care planning across the region
- The Leamington and Area Family Health Team continues to play a leadership role in primary care in the area of advance care planning, and educates its patients on the importance of having earlier conversations about advance care planning

Medical Assistance in Dying (MAID)

The ESC LHIN, through the CCAC, convened a regional steering committee to address MAID in the region. The MAID Regional Steering Committee comprises a network of stakeholder organizations that are creating a framework for regional access for MAID requests. The framework will provide a systems approach that will be consistent throughout the LHIN, to ensure timely responses to requests for information about MAID while being patient-centred and in accordance with current legislation.

The ESC LHIN is committed to ensuring that residents who have life-limiting illnesses have access to timely, high-quality palliative and end-of-life care.

eHealth

TransForm Shared Service Organization (SSO) Regional Project Management Office (PMO)

Three provincial clusters of LHINs (South West Ontario, Greater Toronto Area, and North East Ontario) provide a mechanism to coordinate, plan, implement, and maintain eHealth-enabling solutions in a streamlined fashion across the province. In southwestern Ontario, ESC — in partnership with TransForm — is working with its counterparts in the South West, Waterloo Wellington, and Hamilton Niagara Haldimand Brant LHINs to provide project leadership and oversight for the successful implementation and adoption of projects such as Telehomecare/Telemedicine, eConsult, eReferral, Care Coordination Tool, and Hospital Information System upgrades and replacements. In ESC, nearly 40 high-complexity hospital ehealth and technology projects were rolled out over the course of the last fiscal.

ConnectingOntario and the Connecting South West Ontario (cSWO) Program

ConnectingOntario is a provincial initiative funded by eHealth Ontario that is making Ontarians' health information from across the continuum of care available at any point of care, in a timely and secure fashion. In southwestern Ontario, it is being delivered by the cSWO Program and four change-management and adoption-delivery partners.

In Erie St. Clair, this responsibility belongs to TransForm, which, amongst other initiatives it undertook throughout the year, successfully connected all of the ESC LHIN's hospitals with the province's Digital Health Drug Repository, a valuable tool in addressing the growing opioid crisis. TransForm also continued work on the acute care Clinical Data Repository, successfully contributing patient data sets from three of the region's five hospital information systems to the provincial repository.

Efforts to encourage adoption and meaningful use of the cSWO program's regional clinical viewer, ClinicalConnect™, remained a focus for TransForm's Change Management & Adoption team, as did the ongoing drive to connect area physicians to OntarioMD's Health Report Manager (HRM).

Health System Funding Reform

Under the new model, Ontario's hospitals, CCACs, and long-term care homes are compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve.

The ESC LHIN's health service providers continued to be challenged by the fiscal realities of the health system funding reform, however, primarily because of funding that is based on a population demographic that is declining in size. The ESC LHIN continues to work with its health service providers on mitigation strategies and supports their efforts to align programs and services to provincial benchmarks and develop new and innovative ways to deliver services.

The ESC LHIN will also continue to look for innovations that will help with health system funding reform, such as exploring bundled payments for mild strokes to include rehab, and continuing to explore bundled care by enabling primary care for COPH and CHF patients.

Integration

In 2016–17, the ESC LHIN continued to support integration activities through both formal integration processes and informal activities, such as increasing partnerships and collaboration amongst health care providers.

The ESC LHIN has worked to help health service providers understand that integration does not need to be a formal merger process, and that it is really about increased collaboration so that the care delivery system is more connected and integrated, regardless of formal integration. Increased collaboration amongst all providers ultimately ensures greater sustainability of the health care system and better-coordinated care for patients.

Table 3 outlines the formal integrations that were completed during 2016–17.

Table 3: ESC LHIN Integrations, 2016–17

Date/Event	Organization/Health Service Provider	Motion
	February 28, 2017 **Leamington District Memorial Hospital (LDMH)/Leamington and Area Family Health Team (LAFHT): Voluntary Integration** MOTION: *Moved by Lindsay Boyd and seconded by Michael Hoare that the Erie St. Clair LHIN Board endorses the voluntary integration, and as per our obligation under the* Local Health System Integration Act *(LHSIA), provide notice to Leamington District Memorial Hospital and Leamington and Area Family Health Team that the Erie St. Clair LHIN does not intend to give notice of a proposed decision under subsection (4) or issue a decision under subsection (6), as presented and recommended by LHIN staff.* **Motion Passed**	

Community Engagement

Community engagement is both a legislated responsibility and a core function of the LHINs. Local decision-making is the model upon which the LHINs are built. The LHINs value the input of community members, health care professionals, and stakeholders to inform their planning and decision-making processes.

ESC LHIN key population and stakeholder groups were engaged to further develop relationships, inform planning initiatives, and provide the patient-experience perspective to the work we do. Through this engagement, the ESC LHIN was able to meaningfully meet its overall objectives and responsibilities as outlined in the *Local Health System Integration Act, 2006* (LHSIA). Key population and stakeholder groups included:

- Consumers and families of the health care system
- The Francophone community
- Indigenous and Métis communities
- Health service providers
- Physicians and primary care providers
- Allied health care professionals
- Public health and social service providers

There was significant engagement during 2016–17 with the Erie St. Clair community, patients and their families, and health care providers. Engagement was related to:

- Program-specific engagement, including the ESC LHIN Vision Care Strategy
- ESC LHIN sub-region development

Engagement took many forms, including via patient advisors, meetings, surveys, interviews, social media postings, website updates, and through email. Ongoing engagement also occurred through local provider networks, committees, open board meetings, open mic and online sessions, and formal presentations. Table 5 highlights the ESC LHIN's community engagement activities during 2016–17.

Francophone Engagement

The ESC LHIN remains committed to improving access to health care services in French and bettering the health outcomes of the Francophone population in our LHIN. Throughout 2016–17, several community engagement and planning initiatives were undertaken by the LHIN so that it could better understand and address the health care challenges faced by Francophones in the region. The ESC LHIN also continued to collaborate with the French Language Health Planning Entity (FLHPE) in Erie St. Clair.

Key initiatives this year included the following:

- The French Language Liaison Committee continued its work, with representation from the Erie St. Clair and South West LHINs and the Erie St. Clair/South West FLHPE. This group meets and works on the deliverables from the *Joint Action Plan 2015–2018* to support better health care services for local Francophone residents
- Local conditions continued to be included in LHIN-funded health service provider service accountability agreements regarding the implementation and delivery of French-language services, as well as the collection and reporting of the linguistic identity of health system users. Continued support was provided to health service providers to help them build their capacity to provide French-language services
- Engagement with stakeholders, health service providers, and the Francophone population continued, including attending the Comité Franco Info (Francophone roundtable). Attendance at a roundtable meeting with representatives of Francophone organizations in Sarnia allowed us to initiate discussions about their health care needs
- A targeted engagement with the FLHPE's Board of Directors presented the sub-region concept and obtained their feedback
- As part of the first local Francophone immigration forum, a focus group discussion on health was initiated with stakeholders working with Francophone immigrants to understand the health care needs of Francophone immigrants and discuss potential solutions
- In collaboration with the Windsor-Essex County Health Unit (WECHU), two focus groups were held with Francophones in Windsor and Belle River as part of the development of WECHU's *Strategic Plan 2017–2021*
- The French Language Services Provider Network continued its work. This group promotes the implementation of French-language services, shares information, identifies collaboration opportunities, and discusses challenges

- A number of surveys were made available in French to the Francophone population in Erie St. Clair. Survey topics included the vision care strategy, sub-region development, and patient's first engagement
- A number of interviews were given to French-language media, including one about the development of a vision care strategy
- The Windsor Essex CHC held two series of chronic disease self-management workshops in French for the Francophone community in Windsor and in Stony Point, in an effort to help this population better self-manage chronic diseases
- A French-speaking volunteer was trained to offer falls prevention exercise classes to Francophone seniors in Sarnia
- The development of a series of videos to capture the Francophone patient experience within the health care system and that of health care professionals working with Francophone patients was undertaken in collaboration with the FLHPE

Indigenous Engagement

The ESC LHIN has been working closely with the Indigenous Health Planning Committee (IHPC) to identify and address regional and local health care needs. In January 2016, the IHPC established the following strategic directions for implementation by the ESC LHIN over the next three years:

1. Reduce health inequities for Indigenous people
2. Improve Indigenous patients' access to health and prevention services
3. Improve health system response to Indigenous chronic disease rates
4. Expand availability of mental health/addiction services for Indigenous people
5. Enhance the quality/availability of reliable information/data for health planning

In November 2016, the ESC LHIN Board of Directors approved these strategic directions. The following is a summary of the ESC LHIN advancement of the Indigenous health strategic plan during 2016–17.

Strategic Direction 1: Reduce Health Inequities for Indigenous People

Regional cultural sensitivity/awareness:

- Presentations were given to various health care providers and health care leaders throughout the region. The following is a summary of the presentations and the target audience for each:
  - Aboriginal Title and Consultation: ESC LHIN staff
  - Community Consultation Expectations (given by Chief Miskokomon): ESC LHIN staff
  - Indigenous Health Strategic Plan: ESC LHIN staff, Board of Directors, and Primary Care and Diabetes Clinical Leads
  - Importance of Aboriginal Day: ESC LHIN staff
  - Indigenous Health (Statistics, Cultural Integration Model, and Strategic Plan)

- Centre for Addiction & Mental Health
- Bluewater Health Patient Experience Panel, Senior Leadership, and Board of Directors
- Canadian Mental Health Association: Windsor Essex County Board of Directors
- Hotel Dieu Mission Achievement Team
- Integrated Renal Program Council
- Child and Youth Service Managers

- Indigenous cultural safety (ICS) training:
  - 157 ICS seats were allocated across the region to hospitals and diabetes programs
- Indigenous patient-experience videos:
  - Seven Indigenous patient-experience videos have been recorded
  - Four videos are complete
  - Two videos were reviewed by the participants and approved. These have been posted online and shown at various events
  - Three videos are currently being edited
- Indigenous Health Planning Committee (IHPC) brochure:
  - A brochure explaining the role of the IHPC was created. The brochure will help inform and educate health service providers about the IHPC and its role in setting health priorities locally and regionally. The brochure includes the Cultural Integration Model diagram

Strategic Direction 2: Improve Indigenous Patients' Access to Health and Prevention Services

Primary care providers/allied/wholistic health service provider/primary care provider teams in Indigenous communities:

- Funding allocations provided to Southwest Ontario Aboriginal Health Access Centre (SOAHAC) for continuation of services in Delaware First Nation and Windsor West
- Funding allocations provided to Kettle and Stony Point First Nation for multi-disciplinary health care support
- Home maintenance support provided to Aamjiwnaang First Nation
- Funding allocations provided to Chatham-Kent Community Health Centre for expanded services in Bkejwanong
- Consultation sessions held in Indigenous communities to get feedback on the Patients First proposal
- Consultation sessions held in Indigenous communities regarding the development of recommendations for sub-regions within the ESC LHIN's boundaries

Health system navigation:

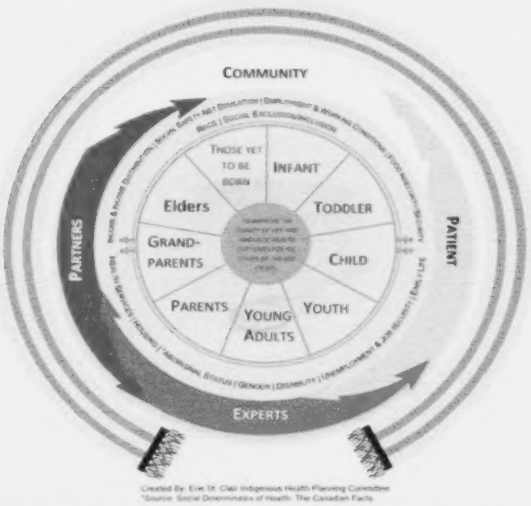
- Bluewater Health's senior leadership agreed to support the inclusion of an Indigenous Patient Navigator within the hospital. The Indigenous Patient Navigator will support Indigenous patients within the hospital, and from hospital to community services (and vice versa)
- Bluewater Health also agreed to establish an Indigenous Patient Experience Committee to support the role of the Indigenous Patient Navigator and enhance their cultural awareness, organizational practices, and procedures
- The IHPC assisted in creating a job description for the Indigenous Patient Navigator
- Bluewater and ESC LHIN representatives meet with Sarnia-Lambton's Member of Parliament (MP) Marilyn Gladu to discuss federal funding opportunities to support the role of the Indigenous Patient Navigator
- A meeting was held between Bluewater representatives and the IHPC to set out the composition and function of the Indigenous Patient Navigator role and the Indigenous Patient Experience Committee

Palliative/hospice:

- An Indigenous palliative care review for the ESC region was conducted by a consultant during the summer and fall of 2016
- A draft report has been completed and its recommendations will be presented to the IHPC in June 2017. The report will help determine priorities and focus areas for the ESC LHIN to advance Indigenous health in the region

Cultural/traditional healing supports:

- Currently, Walpole, Delaware (SOAHAC), Windsor West (SOAHAC), Caldwell First Nation (SOAHAC), and Kettle and Stony Point First Nation receive traditional healing funding



Indigenous youth health care plan:

- A Youth Council was created. The council is currently reviewing options and determining priority areas for advancement
- Two meetings with the Ministry of Child & Youth Services, Mental Health Program Leads (Windsor/Essex, Chatham-Kent, and Sarnia/Lambton) were held. The directors provided an overview of the statistical trends occurring in Indigenous communities and how they are working to align strategic directions

Strategic Direction #3: Improve Health System Response to Indigenous Chronic Disease Rates

Diabetes prevention/service plan for Indigenous patients:

- A meeting was held with the Indigenous Lead at Hamilton Niagara Haldimand Brant (HNHB) LHIN to discuss their diabetes strategy for consideration in the development of the ESC LHIN Indigenous Diabetes Plan
- A meeting with private partners was also held, to discuss the creation of a mobile diabetes health unit for Indigenous communities. Currently, the project is on hold, but once it restarts, a working group (made up of representatives from Indigenous communities) will be created to guide the development of the mobile unit

Strategic Direction 4: Expand Availability of Mental Health/Addiction Services for Indigenous People

Accessibility of mental health and addiction services:

- Meetings were coordinated and facilitated between Kettle and Stony Point First Nation Mental Health Services and local mainstream service providers as a way to share information and set out a referral process

Strategic Direction 5: Enhance the Quality/Availability of Reliable Information and Data for Health Planning

Improve reporting/data mechanisms:

- A field visit was conducted with Walpole Island Home and Community Care to assess its reporting and data tracking processes
- ClinicalConnect™ gave a presentation to the IHPC to demonstrate its electronic health record system and discuss the option of extending this system into First Nation communities. The aim of the service would be to assist with patient support and access, reduce the gaps in discharge planning, and enhance patient follow-up care and support

Report-training sessions:

- As of April 1, 2016, all service providers with a Multi-Sector Accountability Agreement (MSAA) are required to include a language and identity questionnaire summary in their reporting to the ESC LHIN. Patients will be able to then self-identify, if they choose. The aim of this questionnaire is to gain more insight into how many Indigenous patients are accessing health care services at any of the following: hospitals, CHCs, LTC homes, CCACs, community support service agencies, and mental health and addiction services. Through the collection of this information, the ESC LHIN will be able to assess service utilization rates and service gaps for Indigenous patients
- Reporting training ([Ontario Healthcare Reporting Standards [OHRS] and Clinical Assessment Protocols [CAPs]) was provided to Walpole, Kettle and Stony Point and Aamjiwnaang in October 2016

Additional Activities

- The ESC LHIN hosted the annual Provincial Indigenous LHINs Network (PILN) and CEO meeting in May 2016

- The ESC LHIN also developed the PILN's cultural framework

Focus Areas for 2017–18

Increase palliative care supports/options for Indigenous patients/communities:

- Hosting palliative care training for Indigenous community members
- Hosting clinical support training for Indigenous frontline staff

Improve diabetes support/resources for Indigenous patients:

- Development of a regional Indigenous diabetes care/support guideline

Establish/formalize collaborative partnerships between Indigenous and mainstream primary, acute, and mental health service providers:

- Advance Telemedicine options (OTN, Telehomecare) in Indigenous communities.
- Improve patient support in acute and community-based health services
- Develop service and patient referral agreements
- Build health service provider knowledge of culture-based approaches to care/support
- Build Indigenous communities' knowledge of Health Quality Ontario (HQO) standards
- Enhance Indigenous patient supports during transition points between care services or care providers to and from formal/community health services

Table 4 outlines key investments made in Indigenous health care in Erie St. Clair during 2016–17.

Table 4: New or One-Time ESC LHIN Investments in Indigenous Health Care, 2016–17

Region	Program	Funding
Aamjiwnaag First Nation	Home Maintenance program	$25,000
Windsor Essex Community Health Centre	SOAHAC Indigenous Health and Wellness program/clinic	$294,3000

Community Engagement Initiatives

Table 5: ESC LHIN Community Engagement Initiatives, 2016–17

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
Governance	13	Open/special Board meetings	Governance of ESC LHIN and other matters.	Open board meetings are an opportunity for the public to learn more about local health care.
	9	"Open mic" Board meetings	Members of the public can address the ESC LHIN board of directors in an open mic session at each open board meeting.	Relevant issues or questions put before the ESC LHIN board; direct engagement with community members.
	9	Open Board meeting highlights	Highlights of information and decisions from open Board meetings distributed and posted online.	Increased awareness of Board activities and media coverage of important matters.
Governance Advisory Council (GAC) sessions	6 (three sessions held, one in each region) during the spring and fall	Meetings	Revitalization of the GACs. Discussions about the *Patients First Act, 2016*, and ESC LHIN sub-region planning initiatives.	Consensus to continue Board-to-Board governance networking; education and feedback on the *Patients First Act, 2016*, and anticipated responsibilities arising out of the Act.
Chatham-Kent Community Leaders' Cabinet (CKCLC)	4	CKCLC	Community leaders work together to achieve better health outcomes and quality of life for everyone in Chatham-Kent. The ESC LHIN Director of Communications, Public Affairs, and Organizational	The Erie St. Clair Regional Community Data Consortium was initiated; this program provides a venue for collaboration on local research/data, and benefits local

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			Development is a member at this table.	service providers and community partners. The CKCLC also developed a scorecard and strategic document.
Hospice palliative care/end-of-life care	2	Erie St. Clair Hospice Palliative Care Advisory Council	Identify and recommend ways to improve hospice palliative care, provide advice and recommendations to the LHIN on new programs and initiatives, and strengthen a comprehensive, integrated Hospice Palliative Program in Erie St. Clair.	Continued work on priority ESC Hospice Palliative Care Network priority objectives as outlined in the *ESC LHIN Hospice Palliative Care in Erie St. Clair Strategic Plan* re-fresh, which was published in February 2015. Evolution of the Regional Network to support continued alignment with provincial direction and Ontario Palliative Care Network guidelines.
	16 (across the three counties)	Hospice Palliative Care Network local committee meetings	Local engagement to identify service gaps and to plan, coordinate, and review local implementation. Enhances collaboration between people working in palliative care on the frontlines across sectors and settings, and facilitates shared learning.	Provided input into 2016–17 ESC Hospice Palliative Care Network planning as well as involvement in projects at the local level (e.g., emergency medical services [EMS], advance care planning).

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	4	Hospice Palliative Care/End of Life Care Network Education Sub-committee and Health Care Consent/Advance Care Planning Sub-committee	Topics to address identified gaps, including advance care planning, strengthening connection with EMS, and strengthening capability of care providers and volunteers within and across care settings.	Best practices advanced, consistency in messaging, gaps filled, and duplication reduced.
Mental health and addictions	3	ESC LHIN Mental Health and Addictions Network	Responsible for providing high-level strategic counsel to the ESC LHIN to advance system-wide planning, performance oversight for the Leadership Tables, and informed decision-making.	Leadership, monitoring, and oversight of mental health and addictions services, performance, and new funding.
	2	Children and Youth Leadership Table (meetings and focus groups)	Membership includes service providers from school boards, mental health/addictions agencies, Ministry of Children and Youth Services (MCYS), mental health lead agencies, Erie St. Clair CCAC, Schedule One sites, Early Psychosis Programs, etc.	Streamlined transitions in care and strengthened partnerships. Increased networking and overall partnerships.
	18	BSO LTC Road Show	A review of BSO-related data, including ED visits, and BSO internal and external teams.	Key themes/issues brought forward to address, as well as identifying innovative solutions to difficult cases. Roll-up report to be developed regionally and

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
				locally with actions to address concerns raised.
	10	Addictions Implementation Group	Discussed the advancement of the *Addictions Strategic Plan* and implementing changes in the absence of new funding.	Streamlining services, including implementing the GAINs (Global Appraisal of Individual Needs) tool in Sarnia/Lambton and Windsor/Essex.
	3	Psychiatry Leadership Table	This group includes the chiefs of psychiatry from the hospitals as well as community agencies.	Focuses on current issues and spreading best/promising practices.
	1	BSO symposium	Conference held on March 6, 2017, focused on building high-performance teams, compassion fatigue, caregiver support, dual diagnosis and responsive behaviours, and psychotropic medications and the elderly.	More than 180 individuals on a cross-sectorial basis attended. Advanced their core knowledge and capacity-building means.
	1	People with Lived Experience kick-off meeting	25 individuals or family members of individuals who have received mental health or addictions services were brought together to assist in creating a more responsive mental health and	Gained feedback and knowledge from people with lived experience. A working group was created to further discussions.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			addictions system.	
ED/ALC	1	ESC LHIN Executive Nurse/Clinical Leaders Advisory Council	An opportunity for organizations to share expert advice and leadership, and to support, enable collaboration, share models of care, and promote best practices with respect to quality and performance improvement.	Shared knowledge, lessons learned, and successes achieved.
Indigenous	6	IHPC	Regularly scheduled meetings with Indigenous representatives from the area's First Nations, Métis, and Indigenous organizations. Discussions include updates/progress on strategic priority areas, identified initiatives, and partnerships. Presentations are also given.	Participants provide feedback and guidance on priorities for the localized health needs of the region's Indigenous communities.
	2	Youth Council	Facilitated meetings with local Indigenous youth as a sub-group of the IHPC.	Enhancing Indigenous youth health education/literacy and creation of a regional Indigenous Youth Health Care Plan.
	2	Meetings with local Chiefs and ESC LHIN Board Chair/CEO	Updates exchanged and discussion of the health care needs and services within the community.	Positive relationship-building between local Chiefs and ESC LHIN leadership.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	1	Provincial Aboriginal Leads/LHIN meeting	Annual meeting with LHIN CEOs, Indigenous Leads, community members, and Indigenous provincial and territorial organizations. Included a local community showcase, cultural awareness, and working group discussions about priority areas for the next two years.	Creation of provincial Indigenous priorities that the LHINs will advance during 2016–17 and 2017–18
Francophone	2	ESC/SW LHINs and FLHPE Liaison Committee	A forum for collaboration and ongoing dialogue amongst the FLHPE, the South West LHIN, and the ESC LHIN in order to improve health outcomes for the Francophone population in these regions.	Partners work collaboratively to improve access to and accessibility of services in French, with a special focus on priority population groups, including people with mental health and addiction issues, people living with a chronic disease, and seniors and adults with complex needs.
	1	Focus group with stakeholders serving/working with Francophone immigrants	Part of the first local Francophone immigration forum.	To help understand health care needs and discuss potential solutions.
	2	Windsor-Essex County Health Unit focus groups with Francophones	Part of the development of the Windsor-Essex County Health Unit Strategic Plan.	To help understand the health care needs of Francophones.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	1	Engagement with FLHPE Board	Part of the sub-region development.	To present the sub-region concept and obtain the Board's feedback.
	1	ESC LHIN FLS Identified and Designated Providers Network	Forum for improving the accessibility of culturally and linguistically appropriate health services for the Francophone population across the ESC LHIN.	Workshop offered about Francophonie (refers to all peoples and communities anywhere in the world that have French as their mother tongue or customary language) and its multiple diversities.
Rehabilitative care	5	ESC LHIN Rehabilitative Care Committee	Provider- and stakeholder-based committee providing support for system planning, integration, and implementation of strategic initiatives.	Worked toward goals outlined in the refreshed *Rehabilitation System Strategic Plan for the Erie St. Clair Region* (2016–2019) (improved access, system coordination, effectiveness, and efficiencies).
	2	Sarnia/Lambton Stroke Working Group	Group met to talk about planning, improved patient flow, and community care options.	Advancement of specific care paths for each population. Application sent to HQO's Adopting Research To Improve Care fund/program.
	3	Access and Restore Working Group	Group met to talk about implementation of the Seniors Mobile Assess & Restore Team (SMART) model of activation in acute care sites, improved patient	Advancement of best practice care for frail and medically complex seniors admitted to hospital to prevent functional decline.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			flow, and reducing ALC days.	
	1	ESC LHIN Rehabilitation System Evaluation Working Group	Group met to review ESC LHIN rehabilitation system scorecard and alignment to RCA System Evaluation Framework.	Working toward online scorecard accessible to all health service provider partners and aligned with provincial directions in system evaluation.
	1	Fourth ESC LHIN Rehabilitative Care Forum, "Enhancing Geriatric Care Knowledge Exchange Workshop"	Held March 23, 2017, at the Chatham-Kent John D. Bradley Convention Centre. Review of education needs assessment project for geriatric assessment and management. Attended by 55 health service providers across the care continuum in all regions of the LHIN.	Advanced recommendations on a learning plan to meet education needs identified in the survey, and build capacity in geriatric care in acute, post-acute, and community-based health service providers. Introduced a working demo of the Healthline site, categorizing services for seniors based on risk level and care needs for health service providers to facilitate linkage of frail seniors to community supports.
Erie St. Clair sub-region engagement	1	LHIN-funded health service providers: sub-region survey about localized needs and geographic feedback	82 health service providers sent feedback and survey responses.	Gained feedback on sub-region geographic areas and localized health care needs.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	2	LHIN-funded health service providers: webinar	60 participants attended	Provided education on sub-region work and gained feedback on sub-region geographic areas.
	1	LHIN-funded health service providers: geographic options survey	42 responses	Gained feedback on sub-region geographic areas.
	1	General public: survey (also provided in French, and distributed to First Nations communities)	442 responses	Gained feedback on sub-region geographic areas, health care access patterns, and localized health care needs.
	2	General public: webinars	7 participants, including CCAC patient advisors	Gained feedback on sub-region geographic areas, health care access patterns, and localized health care needs.
	3	Community interest group sessions	13 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs.
	3 face-to face meetings (one in each region)	Physician and NP sessions	50 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas.
	1	IHPC	10 participants	Provided education on sub-region work and gained feedback on sub-

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
				region geographic areas.
	5	First Nations communities	30 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs.
	2	Indigenous health centres/health service providers	8 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs.
	1	Primary Care Council	8 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas.
	3 (one in each region)	ESC LHIN Health Service Provider Governance Advisory Councils	41 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs.
	1	FLHPE	7 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs
	3 (one in each region)	Public health units: meetings	6 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	1	Health Equity for Newcomers and Immigrants Working Group	25 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas and local health care needs.
	1 (one staff meeting, 14 individual consultations)	LHIN staff	34 participants	Gained feedback on sub-region geographic areas.
	1	ESC LHIN Governance & Nomination Committee	5 participants	Provided education on sub-region work and gained feedback on sub-region geographic areas.
	1	Erie St. Clair Regional Community Data Consortium meeting on the sub-regions	30 participants, including community stakeholders and all three public health units.	Provided education on sub-region work and gained feedback on sub-region geographic areas; reviewed local data.
Vision Strategic Plan	3	Public engagement sessions (1 per county)	Approximately 25 patients engaged; education session held; gained public input on the state of ophthalmic care in the ESC region.	Gained patient perspective on opportunities for improvement and where to focus strategic plan.
	1	Public/patient survey	261 responses to the English survey and 29 responses to the French survey. Online and paper copies of survey available at health service providers', optometrists', and ophthalmologists'	Gained patient perspective on opportunities for improvement and where to focus strategic plan.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			offices across the region.	
	1	Optometrist survey and information package	Sent surveys and information packages to all optometrists in the Erie St. Clair region. Fourteen optometrists responded.	Gained optometrists' perspective on local state for ophthalmic care; educated them on the current state of vision care strategy.
	2	Telephone meetings with Ontario Association of Optometrists	To discuss how the ESC LHIN can engage local optometrists. Discussed areas where optometrists may be of additional value in providing vision care. Information was shared with the LHIN in the form of a discussion paper.	Information was considered in the report development. Worked with the association to plan and execute engagement initiatives.
	1	Vision Care Steering Committee	Three patient advisors, local ophthalmologists, local hospital staff, and ESC LHIN staff on the committee. Discussed current draft strategy and opportunities for vision care improvement locally.	Edits to draft strategic plan completed based on committee feedback. Plan to be finalized in 2017–18.
Primary care	2	Primary Care Council	A network of primary care providers that advises the LHIN on ways to improve integration and coordination within ESC's primary health care system. The council also focused on ways to increase	Primary care feedback and advice to the ESC LHIN on key initiatives and priorities.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			communication between primary health care providers.	
Critical care	2	Neurological Prognostication After Cardiac Arrest event	Educational event for physicians, NPs, and specialists.	Discussed opportunities for improving quality of care for patients. Presented evidence and research on reviewing treatment options to improve neurological outcomes, as well as ways to better predict the neurological prognosis in patients following a cardiac event.
Quality	1	Quality Council meetings	Provided governance, leadership, and oversight for the quality of health care services, to achieve better care, better experiences, and better value for residents of the Erie St. Clair region.	Work focused on readmissions stroke care.
	3	Regional Quality Table	Focuses on regional quality challenges and initiatives. Helps connect local quality activities with LHIN regional and provincial priorities and structures. Collaboration between the ESC LHIN and HQO.	Worked toward advancing a quality agenda in the ESC LHIN.
Health transportation	6	CareLink Transportation Advisory Group	Regional ESC LHIN-funded health transportation	Implementation of a centralized health transportation

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			providers met regularly, with the goal of standardization and equitable access to health-related transportation.	program with common policies, data collection, and the ability to coordinate scheduling. Also oversaw ESC LHIN investments in new vans to replace some of the current fleet.
Special needs	6	Sarnia/Lambton Special Needs Working Group	Multi-disciplinary and multi-stakeholder group met to identify and recommend LTC placement capacity and processes for people in Sarnia/Lambton with behavioural, neurological, and mental health needs, and to coordinate enhanced care and review placement options for LTC homes dealing with crisis situations resulting from violent behaviours.	Discussed local needs, received proposals, reviewed data, listened to presentations, and heard anecdotes.
Newcomer/ immigrant health	7	Health Equity for Newcomers and Immigrants (HENI) Committee with local health service providers and settlement/ community agencies	Prioritization activities led to advancement of a future-state patient road map with identified system navigators, including VON and Family Services Windsor Essex (FSWE). From the identified gaps, a list of priority activities and expected outcomes was created.	VON Immigrant Health Clinic was funded as a result of Syrian refugee health planning. The team has assessed over 900 patients and has attached nearly 90% of patients to primary care. Twenty percent of patients have been attached to mental health supports with

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
				the addition of FSWE as a partner. Three HENI sub-groups were created to address three priority areas: 1. Access and tracking 2. Language and navigation 3. Information and education for providers Measurable outcomes were identified for each indicator (one per priority group)
Community seniors fairs	1	Tilbury Seniors Fair	ESC LHIN hosted a booth at the Tilbury Seniors Fair. More than 200 seniors attended.	Engaged the seniors' population, enhanced LHIN brand awareness, heard local seniors' needs and concerns.
	1	Chatham Active Lifestyle Centre's Seniors Fair	ESC LHIN hosted a booth at Chatham's Active Lifestyle Centre's Seniors Fair.	Handed out information on CareLink health transportation service, as well as surveys for the ESC LHIN Vision Strategic Plan. Engaged the local seniors' population.
University/ college presentations	3	Presentations	ESC LHIN's CEO, Ralph Ganter; Director of Communications, Public Affairs, and Organizational Development Shannon Sasseville;	Education about the ESC LHIN and health system priorities.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			and Health System Manager Ron Sheppard all presented at local universities/colleges.	
Community presentations	1	Presentation	ESC LHIN's Director of Communications, Public Affairs, and Organizational Development Shannon Sasseville presented at a health care discussion meeting led by Sarnia-Lambton MP Marilyn Gladu that focused on seniors care, now and in the future	Education and discussion regarding the ESC LHIN IHSP 4 data and other seniors' services funded by the LHIN.
	1	Presentation	ESC LHIN's CEO, Ralph Ganter, presented to the Transform Shared Services Office Board at its Board education session.	Update on ESC LHIN strategic priorities, with a focus on the IHSP 4.
	1	Presentation	ESC LHIN's CEO, Ralph Ganter, presented to the victims of Chemical Valley Asbestos and Occupations Disease group in Sarnia.	Education/discussions about ESC LHIN sub-regions, and an opportunity to participate in a survey on sub-regions. Heard local health care concerns and needs from residents.
	1	Presentation	ESC LHIN's CEO, Ralph Ganter, presented to the Lambton Seniors Association Board of Directors in Sarnia.	Education/discussions on seniors' services in Sarnia/Lambton, including LTC homes. Sub-region

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
				survey also distributed.
	1	Roundtable discussion	ESC LHIN's Director of Communications, Public Affairs, and Organizational Development Shannon Sasseville attended a roundtable discussion with the Lieutenant Governor as a member of the Chatham-Kent Community Leaders Cabinet.	Cross-sectorial group that highlighted local successes and brought forward areas of local opportunity and challenges.
Petrolia Community Health Care Hub	4	Joint Bluewater Health and City of Petrolia Steering Committee	ESC LHIN's Director of Communications, Public Affairs, and Organizational Development Shannon Sasseville is an active member. The group is working on master plans for a comprehensive health care community in Petrolia, which includes investments in Charlotte Eleanor Englehart Hospital of Bluewater Health and forging partnerships with various community groups, both health care and community focused.	Master plans and capital requests are in development stages.
Border-incident management planning	1	Two-day planning session — Emergency Management and Planning Office of the Ministry of Transportation	ESC LHIN's Director of Communications, Public Affairs, and Organizational Development Shannon Sasseville attended a two-day	Plans were developed to assist stakeholders in coordinating their individual emergency response plans

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
		and International Safety Research	border-incident management planning session. The group tested drafted response procedures, along with the draft site-specific plans for the Bluewater Bridge in Point Edward and the Ambassador Bridge in Windsor.	when an event occurs at one or more border crossings with the potential to cause significant border delays.

Board of Directors

Name	Position	Location	Tenure
Martin Girash	Chair	Leamington	November 20, 2013–November 19, 2016 November 20, 2016–November 19, 2019
Michael (Mike) Hoare	Vice Chair	Grand Bend	May 17, 2011–May 16, 2014 March 22, 2012–May 16, 2014 (Order in Council as Vice Chair) November 19, 2014–November 18, 2017 (OIC as Vice Chair) (Re-appointment)
Barbara Bjarneson	Director	Windsor	February 9, 2011–February 8, 2014 February 9, 2014–February 8, 2017 (re-appointment) Second term expired February 8, 2017
Robert (Bob) Bailey	Director	Amherstburg	April 18, 2011–April 17, 2014 April 18, 2014–April 17, 2017 (re-appointment) January 23, 2016 (deceased)
Joseph Bisnaire	Director	Windsor	June 2, 2011–June 1, 2014 June 2, 2014–June 1, 2017 (re-appointment)
Donald (Lyndsay) Boyd	Director	Blenheim	September 8, 2014–September 7, 2017
Nora Bressette	Director	Kettle and Stony Point First Nation	June 30, 2016–June 29, 2019
Sheila MacKinnon	Director	Amherstburg	March 8, 2017–March 7, 2020

Ministry-LHIN Accountability Agreement (MLAA)

The MLAA sets out the obligations of the MOHLTC and the ESC LHIN to fulfill the LHIN's mandate to plan, integrate, and fund local health care services. Developing and updating this accountability agreement is a collaborative process that defines the relationship between the MOHLTC and the ESC LHIN, and helps the LHIN strengthen health care in the Erie St. Clair region (see Table 6).

Table 6: ESC LHIN Report on MLAA Performance Indicators

ESC LHIN Report on MLAA Performance Indicators
Among the 14 LHINs, the ESC LHIN is a stronger performer in CCAC wait times, 30-day readmissions, CT scans, and hip surgery wait times. We have made progress in addressing ALC rates, but there is still room to improve, especially in wait times for long-term care. The most significant opportunities for improvement are in wait times for MRI scans and knee replacements, and in EDs. **30-Day Readmissions** The ESC LHIN focused on 30-day readmissions through a further review of the data, especially for patients with COPD and CHF hospitalizations. The process included analysis and sharing of the results with local health service providers, and led to successful outcomes between the 2015–16 and 2016–17 fiscal years. The ESC LHIN sustained a 6% improvement from 2014–15 to 2015–16, and in the last four quarters has had a readmission rate of 15.1%. In the most recent quarter of data (second quarter of 2016–17), the ESC LHIN is the second-best performer in the province, at 16.6%. The ESC LHIN is also looking at process measures to ensure that patients discharged from hospital are connected to community programs through the CCAC. **ALC** Improved discharge planning for complex patients and stronger collaboration between Windsor Regional Hospital and community partners have resulted in substantial year-over-year improvements in the ALC rate at the two hospital sites. However, there are greater opportunities for improvements on discharge planning between hospitals, CCACs, and community partners with respect to post-acute care in Sarnia-Lambton and Windsor West. Post-Acute ALC rates have seen steady increases, especially for patients waiting for long-term care, over the last three quarters of fiscal 2016–17. The overall ESC LHIN ALC rate substantially declined, year over year, at the end of fiscal 2016–17. **Emergency Department LOS** The MLAA includes two ED wait time indicators, one for complex visits and the other for non-admitted minor visits, which have set targets of eight hours and four hours, respectively. These indicators are monitored quarterly through our stock-take/quarterly process. In the first three quarters of 2016–17, the ESC LHIN performed at 9.4 hours for 90th percentile complex LOS, or 9% better than the Ontario wait time. The ESC LHIN is performing close to the Ontario rate for the non-admitted low acuity LOS, at 4.1 and 4.2 respectively, but is still not within the four-

hour target. There are variations in wait times across the LHIN by ED site, which are being addressed through various initiatives.

In addition to the MLAA indicators, the ESC LHIN also monitors the five pay-for-performance ED LOS-related indicators that span the patient journey, from their EMS wait times to their wait times for an acute bed. One of the biggest variances over the last few years has been the time to physician initial assessment (PIA), for which the ESC LHIN has scored poorly against other LHINs and the provincial average. The ESC LHIN advised the region's EDs to focus on improving their time to PIA.

One implementation across the province that proved successful in reducing the time to PIA was RAZ. This was implemented at most sites in the ESC LHIN through pay-for-results ED funding; results varied, however. Through successful implementation of RAZ, Chatham-Kent Health Alliance improved its time to PIA between 2015 and 2016 by over 10%. This also led to improvements in non-admitted high acuity and slightly in non-admitted low acuity. Bluewater Health also slightly improved its time to PIA and dramatically decreased its non-admitted high acuity by over 10%.

Emergency Department Visits Best Managed Elsewhere

In addition to the internal ED improvement initiatives, the ESC LHIN will concentrate on ED/ALC avoidance in the community through its health service providers, home care, CSS agencies, linkages to primary care, and other health and non-allied health providers. This upstream strategy should help decrease the number of ED visits for patients who could safely receive care in a community setting. ED visits best managed elsewhere should, over time, decrease as access to community care and support increases. The ESC LHIN believes that it can help divert patients with unnecessary needs from utilizing the ED and instead receive support in the community.

The ESC LHIN improved on this indicator by reducing the rate of ED visits for conditions best managed elsewhere by almost 50%, from 8.1 in the third quarter of 2014–15 to 4.3 in the second quarter of 2016–17. As of the second quarter of 2016–17, the ESC LHIN is performing approximately 25% better than the Ontario rate of 3.2. Through an analysis to help inform the sub-region geographies, the LHIN found that the outliers in the region are tied to areas with lower areas of primary care access, predominately the rural areas of Sarnia-Lambton and Chatham-Kent.

The ESC LHIN is committed to continually improving local health care. Health system indicators are an excellent way to track results from the system changes the LHIN makes because they are measurable improvements.

No.	Indicator	Provincial					LHIN			
		Provincial target	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year to date)	2014/15 Fiscal year Result	2015/16 Result	Most Recent Quarter	2016/17 Result (year-to-date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within five days of the date that they were authorized to receive personal support services*	95.00%	85.39%	85.36%	82.10%	85.58%	92.45%	90.54%	90.99%	92.21%
2	Percentage of home care clients who received their nursing visit within five days of the date they were authorized to receive nursing services*	95.00%	93.71%	94.00%	93.83%	94.53%	95.04%	95.03%	96.08%	95.74%
3	90th percentile wait time (in days) for CCAC in-home services — application from community setting to first CCAC service (excluding case management)*	21 days	29.00	29.00	29.00	31.00	18.00	19.00	24.00	25.00
4	90th percentile ED length of stay (in hours) for complex patients	8 hours	10.13	9.97	11.03	10.38	8.87	9.67	9.97	9.55
5	90th percentile ED length of stay (in hours) for minor/	4 hours	4.03	4.07	4.23	4.15	4.00	3.98	4.30	4.22

	uncomplicated patients									
6	Percentage of priority 2, 3, and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.43%	40.76%	40.17%	33.71%	44.59%	41.25%	42.65%
7	Percentage of priority 2, 3, and 4 cases completed within access target for CT scans	90.00%	77.77%	74.66%	78.31%	75.89%	95.06%	94.59%	86.81%	89.36%
8	Percentage of priority 2, 3, and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	77.89%	78.47%	83.85%	80.24%	91.13%	87.90%
9	Percentage of priority 2, 3, and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	74.50%	75.02%	75.26%	75.94%	69.73%	72.62%
10	Percentage of ALC days*	9.46%	14.35%	14.50%	15.85%	15.16%	18.07%	15.97%	16.50%	14.30%
11	ALC rate (percentage)	12.70%	13.70%	13.98%	15.27%	15.19%	19.58%	19.50%	15.06%	15.24%
12	Repeat unscheduled ED visits within 30 days for mental health conditions*	16.30%	19.62%	20.19%	20.39%	19.81%	17.05%	17.80%	18.95%	18.59%
13	Repeat unscheduled ED visits within 30 days for substance abuse conditions*	22.40%	31.34%	33.01%	31.15%	31.40%	25.04%	23.99%	28.84%	29.90%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.66%	16.51%	15.51%	14.66%	16.36%	15.76%

2. Monitoring Indicators										
15	Percentage of priority 2, 3, and 4 cases completed within access target for cancer surgery	90.00%	87.02%	88.03%	86.82%	87.23%	85.59%	88.12%	87.02%	86.33%
16	Percentage of priority 2, 3, and 4 cases completed within access target for cardiac by-pass surgery	90.00	96.01	95.00	93.00	*93.00*	*NA*	*NA*	*NA*	*NA*
17	Percentage of priority 2, 3, and 4 cases completed within access target for cataract surgery	90.00	91.93	88.09	85.32	85.01	94.40	84.60	91.57	90.62
18 (a)	CCAC wait times (in days) from application to eligibility determination for LTC home placements: from community setting**	NA	14.00	14.00	14.00	14.00	10.00	10.00	12.00	12.00
18 (b)	CCAC wait times (in days) from application to eligibility determination for LTC home placements: from acute-care setting**	NA	8.00	7.00	8.00	8.00	7.00	7.00	5.00	6.00
19	Rate of emergency visits for conditions best managed elsewhere	NA	19.56	18.47	4.58	12.28	30.57	28.04	5.99	16.35

	per 1,000 population*									
20	Hospitalization rate for ambulatory care-sensitive conditions per 100,000 population*	NA	320.78	320.13	81.88	241.40	384.49	404.45	102.26	306.61
21	Percentage of acute care patients who had a follow-up with a physician within seven days of discharge**	NA	46.09	46.61	47.46	47.81	44.12	44.30	46.07	45.85

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016–17).
**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016–17).

Operational Performance

The ESC LHIN finished 2016–17 with a small surplus, details of which can be found in our statement of operations. Table 7 outlines our funding allocations and operational budget for 2016–17. The statement of operations, which follows this table, provides further information on our allocations and budget.

Table 7: ESC LHIN Funding by Sector

Sector	Funding ($ Million)
Hospital	676.4
Long-term care	220.7
Community Care Access Centres	148.8
Mental health	42.0
Community health centres	35.3
Community support services	22.8
Addictions	10.7
Assisted-living supportive housing	12.3
Acquired brain injury	1.5
LHIN operations	6.5
Total for fiscal 2016–17	**$1,177 (Billion)**

In 2016–17, the ESC LHIN maintained a staff of 34 employees.

During the year, four individuals served as Professional Leads for the ESC LHIN:

- Dr. Eli Malus, Critical Care Lead
- Dr. David Ng, Emergency Department Lead
- Dr. Martin Lees, Primary Care & Clinical Quality Lead
- Dr. Tyceer Abouhassan, Endocrinologist Lead

Projects that continue to receive additional funding from the MOHLTC include:

- Continued support of the French Language Health Planning Entity
- Funding for Indigenous engagement
- Continued support for the Critical Care, Primary Care, and Emergency Department Leads

Statement of Management Responsibility

The accompanying financial statements of the Erie St. Clair LHIN have been prepared by management in accordance with Canadian public sector accounting principles, and the integrity and objectivity of these statements are management's responsibilities.

Management is also responsible for implementing and maintaining a system of internal controls to provide reasonable assurance that reliable information is produced.

The Board of Directors is responsible for ensuring that management fulfills its responsibilities for financial reporting and internal control and exercises this responsibility through the Audit Committee of the Board. The Audit Committee meets with management and the external auditors no fewer than two times a year.

The external auditors, Deloitte LLP, conduct an independent examination, in accordance with Canadian generally accepted auditing standards, and express their opinion on the financial statements. Their examination includes a review and evaluation of the LHIN's system of internal control and appropriate tests and procedures to provide reasonable assurance that the financial statements are presented fairly in accordance with Canadian public sector accounting standards. The external auditors have full and free access to the Performance and Audit Committee of the Board and meet with it on a regular basis.

On behalf of Erie St. Clair LHIN:

Ralph Ganter
Chief Executive Officer

Brady Birkin
Manager, Corporate Services & Controller

May 23, 2017

Financial statements of

Erie St. Clair Local Health Integration Network

March 31, 2017

Erie St. Clair Local Health Integration Network

March 31, 2017

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of operations 4

Statement of change in net debt 5

Statement of cash flows 6

Notes to the financial statements 7-13

Deloitte.

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Independent Auditor's Report

To the Members of the Board of Directors of the
Erie St. Clair Local Health Integration Network

We have audited the accompanying financial statements of Erie St. Clair Local Health Integration Network, which comprise the statement of financial position as at March 31, 2017, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of Erie St. Clair Local Health Integration Network as at March 31, 2017 and the results of its operations, changes in its net debt, and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 23, 2017

Erie St. Clair Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**915,602**	566,842
Due from Ministry of Health and Long-Term Care ("MOHLTC") (Note 7)	**4,253,500**	1,700,855
Accounts receivable	**62,391**	48,935
	5,231,493	2,316,632
Liabilities		
Accounts payable and accrued liabilities	**969,671**	548,326
Due to MOHLTC (Note 10b)	**45,627**	93,318
Due to Health Service Providers ("HSPs") (Note 7)	**4,253,500**	1,700,855
Due to the LHIN Shared Services Office (Note 3)	**-**	5,474
Deferred capital contributions (Note 4)	**142,369**	287,662
	5,411,167	2,635,635
Net debt	**(179,674)**	(319,003)
Commitments (Note 13)		
Non-financial assets		
Prepaid expenses	**37,305**	31,341
Tangible capital assets (Note 5)	**142,369**	287,662
Accumulated surplus	**-**	-

Approved by the Board

M. Hirsh Director

Director

The accompanying notes to the financial statements are an integral part of this financial statement.

Erie St. Clair Local Health Integration Network

Statement of operations
year ended March 31, 2017

	Budget (Note 6)	2017 Actual	2016 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,152,325,441**	**1,170,767,983**	1,141,071,593
Project Initiatives			
Operations of LHIN	**4,348,039**	**4,312,467**	4,160,760
Emergency Department Lead	**75,000**	**75,000**	75,000
Critical Care Lead	**75,000**	**75,000**	75,000
Primary Care Lead	**75,000**	**75,000**	75,000
French Language Health Planning Entities Fund	**425,533**	**425,533**	425,533
Enabling Technologies for Integration Project Management Office	**510,000**	**510,000**	510,000
Diabetes Regional Coordination	**870,561**	**870,561**	870,561
Patients First Transition Planning and Implementation	-	**180,000**	-
Amortization of deferred capital contributions (Note 4)	-	**149,193**	197,063
	1,158,704,574	**1,177,440,737**	1,147,460,510
Funding repayable to the MOHLTC (Note 10)	-	**(8,287)**	(37,340)
	1,158,704,574	**1,177,432,450**	1,147,423,170
Expenses			
Transfer payments to HSPs (Note 7)	**1,152,325,441**	**1,170,767,983**	1,141,071,593
General and administrative (Note 8)	**4,348,039**	**4,454,770**	4,357,227
Project Initiatives (Note 9)			
Emergency Department Lead	**75,000**	**75,000**	73,716
Critical Care Lead	**75,000**	**73,603**	75,000
Primary Care Lead	**75,000**	**75,000**	75,000
French Language Health Planning Entities Fund	**425,533**	**425,533**	390,073
Diabetes Regional Coordination	**870,561**	**870,561**	870,561
Enabling Technologies for Integration Project Management Office (Note 3)	**510,000**	**510,000**	510,000
Patients First Transition Planning and Implementation	-	**180,000**	-
	1,158,704,574	**1,177,432,450**	1,147,423,170
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of this financial statement.

Erie St. Clair Local Health Integration Network

Statement of change in net debt
year ended March 31, 2017

	Budget (Note 6)	2017 Actual	2016 Actual
	$	$	$
Annual surplus	-	-	-
Prepaid expenses incurred	-	(37,305)	(31,341)
Prepaid expenses used	-	31,341	28,299
Acquisition of tangible capital assets	-	(3,900)	(98,776)
Amortization of tangible capital assets	-	149,193	197,063
Increase in net debt	-	139,329	95,245
Net debt, beginning of year	-	(319,003)	(414,248)
Net debt, end of year	-	(179,674)	(319,003)

The accompanying notes to the financial statements are an integral part of this financial statement.

Erie St. Clair Local Health Integration Network

Statement of cash flows
year ended March 31, 2017

	2017	2016
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	**149,193**	197,063
Amortization of deferred capital contributions (Note 4)	**(149,193)**	(197,063)
Changes in non-cash operating items		
Due from MOHLTC	**(2,552,645)**	3,869,645
Accounts receivable	**(13,456)**	19,274
Accounts payable and accrued liabilities	**421,345**	(182,333)
Due to MOHLTC	**(47,691)**	37,340
Due to HSPs	**2,552,645**	(3,869,645)
Due to LHIN Shared Services Office	**(5,474)**	1,772
Prepaid expenses	**(5,964)**	(3,042)
	348,760	(126,989)
Capital transaction		
Acquisition of tangible capital assets	**3,900**	98,776
Financing transaction		
Deferred capital contributions received (Note 4)	**(3,900)**	(98,776)
Net increase (decrease) in cash	**348,760**	(126,989)
Cash, beginning of year	**566,842**	693,831
Cash, end of year	**915,602**	566,842

The accompanying notes to the financial statements are an integral part of this financial statement.

1. Description of business

The Erie St. Clair Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Erie St. Clair Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSPs") are expensed in the LHIN's financial statements for the year ended March 31, 2017.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Municipalities of Essex, Lambton and Chatham-Kent. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN financial statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Chartered Professional Accountants of Canada ("CPA"). Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Government transfer payments

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. Unspent amounts are recorded as payable to the MOHLTC at period end. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related capital asset recorded.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

Tangible capital assets

Tangible capital assets are recorded at cost. Cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

2. Significant accounting policies (continued)

Tangible capital assets

Office equipment	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

3. Related party transactions

LHIN Shared Service Office,LHINC Collaborative and Health Shared Services Ontario

The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs was responsible for providing services to all LHINs. The full costs of providing these services was billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN as at February 28, 2017 were recorded as a receivable (payable) from (to) the LSSO. This was done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC was to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC was a LHIN-led organization and accountable to the LHINs. LHINC was funded by the LHINs with support from the MOHLTC.

Effective February 28, 2017 pursuant to a transfer agreement between Toronto Central LHIN and Health Service Shared Services Ontario (HSSO) responsibility for the shared services previously provided by the LSSO and the LHINC was transferred to HSSO. HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long Term Care.

Enabling Technologies for Integration Project Management Office

Effective February 1, 2012, an agreement was formed with Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from South West LHIN of $510,000 (2016 - $510,000). The LHIN had a contract and retained services of the Transform Shared Service Organization ("Transform"). All funds were expended.

4. Deferred capital contributions

	2017	2016
	$	$
Balance, beginning of year	**287,662**	385,949
Capital contributions received during the year	**3,900**	98,776
Amortization for the year	**(149,193)**	(197,063)
Balance, end of year	**142,369**	287,662

5. Tangible capital assets

			2017	2016
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment	**858,911**	**783,129**	**75,782**	149,199
Leasehold improvements	**955,933**	**889,346**	**66,587**	138,463
	1,814,844	**1,672,475**	**142,369**	287,662

6. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the initial budget at April 1, 2016. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $1,170,767,983 is derived as follows:

	$
Initial budget	**1,152,325,441**
Adjustment due to announcements made during the year	**18,442,542**
	1,170,767,983

The final LHIN budget, excluding the HSP funding, of $6,523,561 is derived as follows:

	$
Initial budget	**6,379,133**
Change in funding from the MOHLTC during the year	**180,134**
Amount treated as capital contributions made during the year	**(3,900)**
In-Year recoveries by the MOHLTC during the year	**(31,806)**
	6,523,561

7. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $1,170,767,983 (2016 - $1,141,071,593) to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2017 as follows:

	2017 $	2016 $
Operation of hospitals	**676,437,991**	660,071,256
Grants to compensate for municipal taxation - public hospitals	**172,500**	172,500
Long-term care homes	**220,720,033**	220,699,564
Community care access centres	**148,779,255**	140,525,653
Community support services	**22,826,637**	22,103,369
Assisted living services in supportive housing	**12,322,437**	11,685,084
Community health centres	**35,250,458**	32,171,091
Community mental health addictions programs	**12,213,804**	12,065,046
Community mental health programs	**42,044,868**	41,578,030
	1,170,767,983	1,141,071,593

The LHIN receives money from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2017, an amount of $4,253,500 (2016 - $1,700,855) was receivable from the MOHLTC and payable to HSPs. These amounts have been reflected as revenue and expenses in the statement of operations and are included in the table above.

8. General and administrative expenses

The statement of operations presents the expenses by function. The following classifies general and administrative expenses by object:

	2017 $	2016 $
Salaries and benefits	**3,250,923**	2,930,366
Occupancy	**333,878**	358,425
Amortization	**149,194**	197,063
Shared services	**268,769**	313,194
Public relations	**17,265**	53,680
Consulting services	**44,866**	54,584
Supplies	**17,391**	28,001
Board Chair per diems	**41,650**	43,925
Board member per diems	**40,100**	46,550
Board member expenses	**59,218**	49,260
Obstetrics expert panel	**-**	4,785
Mail, courier and telecommunications	**37,206**	37,004
LHIN collaborative	**38,000**	38,000
Other	**156,310**	202,390
	4,454,770	4,357,227

9. Project Initiatives

The LHIN received funds for various project initiatives reported in the statement of operations. Details of expenses incurred in relation to the Diabetes Regional Coordination Centres are as follows:

	Budget	2017	2016
	$	$	$
Salaries and benefits	**681,330**	**701,487**	666,710
Operating expenses	**189,231**	**169,074**	203,851
General and administrative expenses	**870,561**	**870,561**	870,561

Expenses incurred in respect of all other initiatives were for professional services.

10. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2017 Excess funding	2016 Excess funding
	$	$	$	$
Transfer payments to HSPs	**1,170,767,983**	**1,170,767,983**	**-**	-
LHIN operations	**4,312,467**	**4,305,577**	**6,890**	596
Project Initiatives				
French Language Health Planning Entities Fund	**425,533**	**425,533**	**-**	35,460
Critical Care Lead Fund	**75,000**	**73,603**	**1,397**	-
Primary Care Lead Fund	**75,000**	**75,000**	**-**	-
Emergency Department Lead	**75,000**	**75,000**	**-**	1,284
Diabetes Regional Coordination	**870,561**	**870,561**	**-**	-
Enabling Technologies	**510,000**	**510,000**	**-**	-
LHIN Transition Planning	**180,000**	**180,000**	**-**	-
	1,177,291,544	**1,177,283,257**	**8,287**	37,340

b) The continuity of the amount due to the MOHLTC at March 31 is as follows:

	2017	2016
	$	$
Due to MOHTLC, beginning of year	**93,318**	55,978
Funding repayable to the MOHLTC related to current year activities (Note 10a)	**8,287**	37,340
Amounts repaid to MOHLTC during the year	**(55,978)**	-
Due to MOHLTC, end of year	**45,627**	93,318

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 33 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2017 was $314,335 (2016 - $283,144) for current service costs and is included as an expense in the statement of operations. The last actuarial valuation was completed for the plan as at December 2016. Currently, the plan is fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has funding commitments to health service providers associated with accountability agreements. The LHIN had the following funding commitments as of March 31, 2017.

	$
2018	808,599,254

The LHIN also has commitments under various operating leases related to building and equipment, which will be renewed in accordance with standard lease terms. Minimum lease payments due in each of the next five years are as follows:

	$
2018	345,898
2019	336,098
2020	327,974
2021	326,401
2022	326,401
	1,662,772

14. Subsequent events

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the Erie St. Clair Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employess of the CCAC.

Effective June 21, 2017 the LHIN will assume the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

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